DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/06/2011 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155001		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED 03/10/2011		
		100001	B. WIN	V 1 1			
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
HOOVEE	NACOD				OOVER RD		
HOOVEF	RWOOD			I INDIAN.	APOLIS, IN46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000	This visit was for State Licensure S	r a Recertification and Survey.	F00	00			
	Survey dates: M	arch 7, 8, 9 & 10, 2011					
	Facility number:	000001					
	Provided number						
	AIM number:	100275310					
	Anvi number.	1002/3310					
	Curron toom						
	Survey team:	TC					
	Diana Zgonc RN						
	Connie Landman						
	Courtney Hamilton						
	Christi Davidson	RN					
	Canava had tama						
	Census bed type:	170					
	Total:	170					
	Census payor typ	ne.					
	Medicare:	26					
		100					
	Other:	44					
		170					
	10ta1.	1/0					
	Sample:	26					
	Supplemental sar	mple: 3					
	-	also reflects state findings ce with 410 IAC 16.2.					
	Quality review co	ompleted 3/17/11 by N.					
LABORATOR	Y DIRECTOR'S OR PROV	TDER/SUPPLIER REPRESENTATIVE'S SIG	TITLE		(X6) DATE		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

41L811

Facility ID:

000001

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NAME OF PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	1
HOOVEF	RWOOD			OOVER RD JAPOLIS, IN46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE

STATEMENT OF DEFICIENCIES X1) PROV		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			COMPLETED	
		155001	A. BUILDING B. WING			03/10/2	011
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				OOVER RD		
HOOVER	RWOOD				APOLIS, IN46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0441	Based on observa	ation, record review and	F04	41	F441		04/04/2011
SS=E	interview, the fac	cility failed to ensure					
	handwashing and	d glove changes were			There have been residents found to have been	no	
	_	ntrol and prevent the			affected by this deficient practi	ice	
	_	ons according to facility			and denoted by the denotern proces		
		residents observed			2. Due to this plan of	of	
					correction which will include		
		iring handwashing in the			inservice education, disciplina	ry	
	_	13 of 3 residents in the			action, staff demonstration of		
	* *	nple of 3 during 4 of 10			proper hand washing techniqu	e,	
	handwashing obs	servations (Residents			and close staff supervision by Unit Managers, Nursing		
	#138, #93, #140,	#128, #57).			Supervisors, Nursing		
					Administration, and the Infection	on	
	Findings include	:			Prevention Nurse, it is unlikely		
					that other residents will have t		
	1 Pavian of a a	current facility policy,			potential of being affected by t	his	
					same deficient practice.		
	•	Administrator on 3/9/11			l		
		ed "HAND HYGIENE",			3. Inservices will tal	ке	
	revised 10/09, in	dicated:		place, for nursing and		the	
	"Purpose:		non-nursing personnel, during the week of March 28, 2011. During				
	To prevent and c	ontrol the spread of			these inservices, this deficience	-	
	infectious organi	sms			will be communicated to the st		
	Policy:				and hand washing procedures	i	
	_	ashed at the following			with return demonstrations will		
		e with regulatory			occur. In addition, "Hand	,,	
		e with regulatory			Washing for Healthcare Worke		
	guidelines				laminated cards to attach to th name badge lanyard will be	eii	
	Procedure:				distributed to those employees	,	
		sh their hands at the			who currently do not have one		
	following times:				{see inservice attendance, "H		
	Before and after direct resident contact				Hygiene" policy, pictures, and		
					"Hand Washing for Healthcare		
	Before and af	ter assisting a resident			Workers" name badge card.}		
		re (activities of daily			   L.P.N. #1, C.N.A. #2, Q.M.A. #	<sub>+3</sub>	
	living	- ()			and L.P.N. #4 all participated i		
					and En in in in participated i		
			1				

STATEMEN	TATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A DIIII	A. BUILDING			COMPLETED		
155001		1	B. WING			03/10/2011		
			D. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF I	PROVIDER OR SUPPLIEF	₹			OOVER RD			
HOOVER	SMOOD			1	IAPOLIS, IN46260			
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	l '	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE.	COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	·	in a	DATE	
		assisting a resident with			individual inservices with Nurs Administration during the weel			
	1 -	oap and water			March 28, 2011. The deficient			
	1	g soiled or used linens,			observations that they were ea			
	dressings, bedpa	ns, catheters and urinals			involved in were carefully			
					reviewed and they were requir	ed		
	Before and aft	ter changing a dressing			to demonstrate proper hand			
		g gloves or aprons			washing technique. All four			
		If be washed with soap			employees received disciplina documentation in their employ			
		ever visibly soiled as			files. {see disciplinary	ee		
	follows:	ever visibly solled as			documentation}			
					,			
		vrists with comfortably			4. These deficient			
	warm water				practices will be closely			
	Apply soap to	hands and while			monitored on a regular basis b	у		
	interlacing the fi	ngers and moving the			the Unit Managers, Nursing			
	hands back and	forth over the front, back,			Supervisors, Nursing Administration, and the Infection	n		
	under fingernails	s if visibly soiled, and			Prevention Nurse. Any deficie			
	I -	friction to create lather			practices observed will be			
	for fifteen (15) s				followed up accordingly with			
	` ′	d waterless antiseptic			disciplinary action, further			
		-			inservice education, etc. Any			
	l -	vailable in areas where			trend of deficient practices			
	1	access to soap and water			identified will be reported at th	e		
	1	l only if hands are not			monthly Quality Improvement Committee Meetings. Any			
	visibly soiled".				specific follow-up intervention			
					including disciplinary action,			
	2. During a dres	ssing change observation			policy development, inservice			
		5 A.M., LPN #1 was			education, etc., will be			
		·			implemented and monitored as	s		
	observed bringing supplies for the dressing change into Resident #138's room. LPN #1 put gloves on, then				necessary.			
					5. Date of Completion:			
					5. Date of Completion.			
	_	ves, used hand sanitizer,						
	1 1	oves on. LPN #1 then						
	removed the resi	dent's left foam bootie						
	and sock and the	old dressing from the						

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NAME OF F	PROVIDER OR SUPPLIER	<b>!!</b>	STREET ADDRESS, CITY, STATE, ZIP CODE  7001 HOOVER RD INDIANAPOLIS, IN46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES  ICY MUST BE PERCEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	D BE	(X5) COMPLETION DATE		
	hands or changing proceeded to spread to spread to spread to spread to spread to spread to swab stick and prover the wound. LPN #1 over the wound, with gauze roll, a hold it in place. The gloves and we seconds before proven and putting the respect to bootie back on.  During an interval Control RN on 3 indicated she word gloves to have be cleaned, and clear	Without washing her ag gloves, LPN #1 ay cleanser on the wound. dicated ointment on a ut the ointment into the placed a foam dressing and wrapped the ankle and taped the gauze to LPN #1 then removed rashed her hands for 15 outting on clean gloves esident's sock and foam iew with the Infection /9/11 at 10:15 A.M., she ould have expected the een removed, hands an gloves put on before e cleanser and ointment ang change.						

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NAME OF P			STREET ADDRESS, CITY, STATE, ZIP CODE  7001 HOOVER RD INDIANAPOLIS, IN46260				
	155001 PROVIDER OR SUPPLIER		F04	STREET A 7001 HO INDIAN ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  F441  1. There have been residents found to have been affected by this deficient praction.  2. Due to this plan of correction which will include inservice education, disciplinariaction, staff demonstration of proper hand washing technique and close staff supervision by Unit Managers, Nursing Supervisors, Nursing Administration, and the Infection Prevention Nurse, it is unlikely that other residents will have the potential of being affected by the same deficient practice.  3. Inservices will take place, for nursing and non-nursing personnel, during week of March 28, 2011. During these inservices, this deficience will be communicated to the stand hand washing procedures with return demonstrations will occur. In addition, "Hand Washing for Healthcare Workel laminated cards to attach to the name badge lanyard will be	no ce. of ry e, on he his ke the ng cy aff	(X5) COMPLETION DATE 04/04/2011
					distributed to those employees who currently do not have one {see inservice attendance, "Hat Hygiene" policy, pictures, and "Hand Washing for Healthcare Workers" name badge card.}  L.P.N. #1, C.N.A. #2, Q.M.A. # and L.P.N. #4 all participated in	and #3,	

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155001	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY COMPLETED 03/10/2011		
NAME OF PROVIDER OR SUPPLIER  HOOVERWOOD			STREET ADDRESS, CITY, STATE, ZIP CODE  7001 HOOVER RD INDIANAPOLIS, IN46260				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE COPRIATE	(X5) COMPLETION DATE	
				individual inservices with Administration during the March 28, 2011. The defi observations that they we involved in were carefully reviewed and they were not demonstrate proper hat washing technique. All for employees received discit documentation in their emfiles. {see disciplinary documentation}  4. These deficit practices will be closely monitored on a regular batthe Unit Managers, Nursing Administration, and the Intervention Nurse. Any disciplinary action, further inservice education, etc. trend of deficient practice identified will be reported monthly Quality Improvent Committee Meetings. An specific follow-up interver including disciplinary action, etc., will be implemented and monitor necessary.  5. Date of Completica 4/4/11	week of icient ere each equired and our plinary aployee ent essis by a at the anent y at the anent y at the anent ere each ere ea		

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		155001	B. WING			03/10/2011	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIER				OOVER RD		
HOOVEF	RWOOD				IAPOLIS, IN46260		
					+		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TΕ	COMPLETION DATE
TAG		LSC IDENTIFYING INFORMATION)	F0.4		F441	+	
F0441	_	ication pass observation	F04	41	[44]		04/04/2011
SS=E	· ·	:00 A.M., QMA #3, was			1. There have been	ino	
	observed comple	ting a blood pressure			residents found to have been		
	reading on Resid	ent #140 in the C dining			affected by this deficient practi	ice.	
	room. QMA #3	returned to the					
	medication cart a	and pulled the			2. Due to this plan of	of	
		Resident #140. She did			correction which will include	_,	
		ds or use hand sanitizer.			inservice education, disciplina action, staff demonstration of	ıy	
		as available on the			proper hand washing technique	<sub>ie.</sub>	
		QMA #3 administered			and close staff supervision by		
					Unit Managers, Nursing		
		to Resident #140. QMA			Supervisors, Nursing		
		e medication cart and did			Administration, and the Infection		
	not wash her han	ds or use hand sanitizer.			Prevention Nurse, it is unlikely		
	She obtained the	mobile blood pressure			that other residents will have t potential of being affected by t	- 1	
	machine, which	was located next to the			same deficient practice.	.1115	
	medication cart,	and returned to the C			Came denoisin practice:		
	dining room. QN	MA #3 obtained a blood			Inservices will tal	ke	
	pressure reading	on Resident #128. QMA			place, for nursing and		
		e medication cart. She			non-nursing personnel, during		
		hands or use hand			week of March 28, 2011. Duri these inservices, this deficient		
		illed the medications for			will be communicated to the st	, ,	
	Resident #128.	med the medications for			and hand washing procedures		
	Resident #128.				with return demonstrations will		
					occur. In addition, "Hand		
	_	ication pass observation			Washing for Healthcare Worke		
	· · · · · · · · · · · · · · · · · · ·	0:30 A.M., after the			laminated cards to attach to th	eir	
	-	ed a breathing treatment,			name badge lanyard will be distributed to those employees	, l	
	LPN #4 returned	to the resident and used			who currently do not have one		
	her bare right har	nd to asses the pulse rate			{see inservice attendance, "H		
	_	esident # 57. Before			Hygiene" policy, pictures, and	•	
		ent's room, LPN #4 put			"Hand Washing for Healthcare	,	
	-	der soap and water and			Workers" name badge card.}		
		rs together of her right					
	hand for less that	-			L.P.N. #1, C.N.A. #2, Q.M.A. #		
	manu for less that	n 13 seconds.			and L.P.N. #4 all participated i	"	

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NAME OF F	PROVIDER OR SUPPLIER	2	STREET ADDRESS, CITY, STATE, ZIP CODE 7001 HOOVER RD INDIANAPOLIS, IN46260					
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	3.1-18(1)			individual inservices with Nur- Administration during the wee March 28, 2011. The deficier observations that they were estinvolved in were carefully reviewed and they were requited demonstrate proper hand washing technique. All four employees received disciplinated documentation in their employ files. {see disciplinary documentation}  4. These deficient practices will be closely monitored on a regular basis the Unit Managers, Nursing Supervisors, Nursing Administration, and the Infect Prevention Nurse. Any defici practices observed will be followed up accordingly with disciplinary action, further inservice education, etc. Any trend of deficient practices identified will be reported at the monthly Quality Improvement Committee Meetings. Any specific follow-up intervention including disciplinary action, policy development, inservice education, etc., will be implemented and monitored a necessary.  5. Date of Completion: 4/4/11	ek of it ach red ary yee by ion ent			